



Cameron, A., Allen, P., Williams, L., Durand, M. A., Bartlett, W., Perotin, V., & Hutchings, A. (2015). Increasing autonomy in publically owned services: The case of community health services in England. *Journal of Health Organization and Management*, 29(6), 778-794.
<https://doi.org/10.1108/JHOM-06-2014-0098>

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Increasing autonomy in publicly owned services: the case of community health services in England

The past two decades have seen a trend in the management of public services to introduce mechanisms found more usually in the private sector. A prominent aspect of this so called 'New Public Management', 'NPM', (Hood, 1991, Clarke and Newman, 1997) is the introduction of different levels of institutional autonomy combined with market incentives in an attempt to improve public services. The objectives of these changes are to improve the internal efficiency of the public organisations; improve user satisfaction; and improve public accountability and transparency (Le Grand and Bartlett, 1993; Pearson, 2000; Boyne 2003a). The economic theory behind these policies is that bureaucratic and monopolistic public management causes inefficiency (Buchanan and Tollison, 1984), and that increasing the autonomy of public organisations in the context of a degree of market competition should improve both financial and quality performance by creating stronger incentives for managers to induce their organisations to perform better (Le Grand and Bartlett, 1993).

The degree to which institutional autonomy and marketization has been introduced varies between different parts of the public (or former public) sector. In this context, autonomy can be understood as autonomy from oversight in the form of goal setting or supervision over operational decisions and therefore denotes greater discretion in tasks and function (McGrath, 2001). Marketization can be understood as the introduction of competition on the supply side (and sometimes, but not always, changes to the demand side as well). In general, proponents argue that the granting of autonomy to public sector organisations is likely to lead to enhanced performance if there are sufficient incentives to change behaviour, for example rights to keep profits as well as accepting financial risks (Verhoest et al, 2004). As Anand et al argue '... from a political and managerial perspective, autonomy is often aimed at inputs and processes while offering the prospect of some outcome control.' (2012: 210).

Publicly owned health services across the globe have been subject to increasing autonomy (Duran et al, 2011, Allen et al 2013). In many countries public hospitals traditionally operated under a 'command and control' model, where decisions were made at a governmental level higher than that of the hospital itself. Problems identified by critics of this model of governance include the inability to separate local operational decisions inside the hospitals from the overall policy responsibility of politicians (Duran et al, 2011); the slowness and unresponsiveness of local decision making (Allen, 2006); resulting in inefficient and poor quality services (Allen and Wang early view). In order to deal with the problems perceived to be caused by 'command and control' structures, the goal of increasing autonomous management for public hospitals has been pursued in many countries since the late 1980s (Saltman *et al*, 2011). Clearly, no hospital will be fully autonomous, as there will be government and regulatory frameworks to which it must adhere. Autonomy can be seen as a continuum, which involves degrees of delegation of responsibility for the operational management of hospital services (and sometimes strategic management too) from central ministries of health to hospitals themselves (Pearson, 2000).

In the case of English health services, the policy of increasing autonomy of health care providers needs to be understood in the context of general quasi market reforms originally introduced in the early 1990s (DH, 1989). The English NHS is a tax funded healthcare system, free at the point of use for all patients. Until recently, it was run from the national Ministry of Health (known as the Department of Health - DH) (Health and Social Care Act 2012). Providers of care have generally been state owned. An internal market for community, secondary and tertiary health care was produced by introducing a split between the state owned purchasers of care and its providers (also state owned). The hospitals and other healthcare services were transferred into state owned organisations called 'self governing Trusts'. The previous system of annual budget allocations was replaced with negotiated contracts between purchasers and providers. The detailed configurations of the state owned purchasers has changed over the

years. The first were health authorities and general practitioners who held funds to purchase some aspects of healthcare – fundholders; moving to primary care trusts – PCTs; and currently clinical commissioning groups – CCGs. In each configuration the state owned commissioner was responsible for deciding which competing health care delivery organisation would be chosen to provide services to its resident population.

Autonomy in the English NHS: Foundation Trusts

NHS Foundation Trusts (FTs) were first set up in 2004. They were conceived as a new kind of organisational form, still part of the NHS, but modeled on ‘co-operative and mutual traditions’ (Allen et al 2012). The formal governance structures of FTs are different from other NHS Trusts in two distinct ways: First, FTs have greater autonomy, and less accountability to the central NHS. Secondly, they are required to have members and governors drawn from staff, patients and local residents, which were new classes of stakeholders for NHS hospitals. The government saw the new status of FT as offering the potential for more rapid creation of new services, greater patient involvement in decision-making about services and a more business-like and efficient approach (DH, 2005). Although FTs have greater freedom to manage their finances, including being able to keep any surplus they make, as well as being able to borrow money from whomever they wish, they are required to use their assets solely as a means to improve the healthcare services they deliver and cannot distribute any surplus to staff or members. The increased autonomy from the DH granted to FTs was twinned with increased accountability at local level. Although Allen and Jones (2011) report some evidence to suggest that FTs used their new found autonomy to develop services that were more responsive to their local populations, there is no evidence that the change of status from NHS Trust to FT has in fact engendered improvements in performance. Superior performance pre-dated elevation to FT

status, and was one of the key factors in allowing those hospitals to be granted FT status (Verzulli et al, 2011). Moreover, there is no clear evidence to date that accountability to local communities has been improved by the addition of governors and members to the governance structures of FTs (Allen et al, 2012). In general, empirical evidence about the impact of reforms to the public sector suggests that the availability of resources and the quality of management appear to influence performance more consistently than changes to regulation, organizational structure and market structure (Boyne 2003b).

This paper contributes to our understanding of changing organizational forms aimed at increasing autonomy by the granting of FT status within the English NHS by reporting a study of changes in the organisation of health care delivered in the community. This is a unique contribution to the field because all the evidence to date has concerned the formation and performance of hospital FTs. This study concerned community health services (CHS), such as district nursing and health visiting, services delivered by staff working in the community rather than in hospitals. The paper explores why some CHS had elected to join the pathway to Community Foundation Trust (CFT) status while others had not; and what advantages they thought the different organisational forms available to them would have. The study reveals that regardless of the different pathways that organisations were on in respect of CFT status, they all shared the same goal, a desire for greater autonomy. Additionally, irrespective of their organisational form most organisations were considering an almost identical set of initiatives to become more efficient. Thus it does not appear that CFT status was the salient issue in increasing autonomy.

Changes in the organisation of CHS

In order to understand the latest set of organisational changes to CHS, it is necessary to briefly explain the recent history of these services in the English NHS. CHS have been subject to large scale organisational changes in the past two decades. On the introduction of the internal market to the NHS in the early 1990s, CHS were transferred to NHS Trusts. CHS could be the sole services in a trust or combined with acute hospital services and/or mental health and learning disability services. In the late 1990s under New Labour, CHS were integrated with commissioners of services in Primary Care Trusts (PCTs). By the mid-2000s, New Labour had decided that CHS should be organisationally separated from commissioners so that they would be subject to greater autonomy and supply side competition. One potential organisational form for CHS was the creation of CFTs which would have the same governance structures as existing hospital and mental health FTs. Alternatively CHS could integrate with acute services (vertical integration) or with other community based services such as mental health and/ or social care providers (horizontal integration). Another potential organisational form for CHS was to 'spin out' of the NHS to form independent social enterprises run by their staff (Spilsbury and Pender early view).

Study Design and methods

In 2007 the Department of Health initiated a pilot programme to establish a number of CFTs, with an evaluation of the programme commissioned from us in 2008 (Authors name 2011). In April 2008, some of these pilots became arms-length autonomous provider organizations (APrOs) within their PCTs. These organizations operated under a trial period of 'separation' with autonomous governance as a precursor to converting to full CFT status. APrOs that were

able to demonstrate managerial ability and financial stability and which were approved by the regulatory body Monitor, would be eligible to become CFTs from April 2009. One of the aims of the evaluation was to explore the reasons why providers of CHS aspired to become CFTs rather than taking on other organisational forms, and to see what impact this decision had on the way they organised their services.

Initially, it was envisaged that up to six PCTs within the CFT pilot programme along with a matched comparator sample of PCTs, would take part in the evaluation. However, due to a series of announcements from the Department of Health delaying the formation of any CFTs and making different recommendations for the organisational future of many local CHS after the commencement of the study, it was necessary to change the design of the study as we were conducting it. No CFTs were formed during the course of the study and some of the pilot CFT sites decided not to continue. Some additional CFT pilot sites were also announced and we recruited two of these 'new' CFT pilots to the study. See table 1 for a detailed explanation of the changing organisational destinations of the services in the study.

[Insert table 1 here]

Despite the initial expectations of policy makers, no CFTs were established during the course of the study (and in fact none has been established at the time of writing in March 2014). This meant that it was not possible to investigate the new forms of local accountability, as these had not come into being. Although full CFT status was not achieved by any of the services, they were all starting to become autonomous from the PCT commissioning organisations which they had been merged with in the late 1990s. We therefore decided to interview informants in all of the participating sites, focusing on participants' *expectations* of CFT status, or why they were not planning to become CFTs; changes already made to decision making and governance; and the organisational changes envisaged both to clinical services and managerial arrangements. A

total of 44 staff in 14 organisations were interviewed. Interviewees were purposively selected to include people who were involved in initial discussions about changing organisational status and/or were centrally involved in the work of the pilots.

[Insert table 2 here]

The interviews took place at distinct points in time between April 2009 and December 2010, in order to attempt to capture respondents' views on CFT status during a period of policy change and uncertainty. The *first set of interviews: April 2009 to February 2010* was designed to find out why the pilots wanted to become CFTs and what advantages they thought it would bring. The comparators were included to explore contrasting views from organisations which were not destined, at that time, to be CFTs. The *second set of interviews: June 2010 to December 2010* took place after the change in government in May 2010, the majority being completed after the Coalition government's White Paper setting out major changes to the NHS 'Equity and Efficiency: Liberating the NHS' (Secretary of State, 2010) was published in July 2010. The White Paper confirmed that the policy of converting NHS Trusts into FTs, including the formation of CFTs would continue. The purpose of this set of interviews was to include some additional organisations which were announced as being destined to become CFTs. As with the first set, the aim was to find out why the organisations wanted to become CFTs (or a social enterprise) and what advantages they thought it would bring. A *third set of interviews: June 2010 to November 2010* consisted of all organisations that had never been or were not now following a CFT pathway.

Semi-structured interviews were conducted, using a topic guide based on the questions the study was designed to answer. The interviews were digitally recorded and fully transcribed. The transcripts were coded initially in relation to the themes which were the original focus of the study concerning the effect of CFT status on managerial issues and supplemented with themes

that emerged from the data; for example, reflecting the changes in policy during the study (Creswell, 2009). The transcribed interviews were coded and analysed thematically by at least two members of the research team. The two sets of coding were compared and any discrepancies discussed and resolved.

Ethical approval was granted by the principal applicant's university and the NHS ethics service confirmed that NHS ethical approval was not required, as the study was an evaluation. Research governance approval was obtained from each site. In keeping with established practice all participants were asked to give informed consent and data were stored anonymously on password protected servers (ESRC, 2010). Each participating organisation was assigned a unique code; these codes are used to present the data in this paper. CFT pilot sites are coded with a number and the letter A, all other sites are coded with a number and the letter B – see table 1. This paper presents findings in an aggregated fashion, with quotes evidencing themes arising from the analysis. We have also identified the case study sites, from which the reader can see that there were no significant differences concerning attitudes to autonomy between sites.

Results

1. Consideration of organizational form

The results of the study demonstrate that the organisational form was not the main focus of interest to those running CHS, but remaining part of the NHS while achieving greater autonomy from higher levels of NHS management (including their PCT colleagues and central Department of Health) was.

The results provide an insight into the reasons why some organizations applied to become CFTs rather than pursuing other organizational forms such as vertical integration or becoming a social enterprise. The data suggests that organizations wanted to achieve greater autonomy, particularly when it brought with it the opportunity to retain any financial surplus the organization made. Significantly however, they wanted to be autonomous within the NHS.

All participants representing CFT pilots described how the flexibilities associated with becoming a CFT, and particularly the autonomy that separation from the PCT implied, had been the main factor in their decision to apply to become a CFT. As a respondent at site 3A commented, CFT status allowed them *'to be independent of the PCT'* whilst a colleague said it provided

"a degree of autonomy and freedom of movement that you don't necessarily see in the other governing structures".

Importantly, as a participant at site 2A noted, the new financial flexibilities afforded by becoming a CFT would enable the organisation to *'retain our savings and reinvest in patient care'*. The potential to retain any surplus was also a major driving force behind the decision to become a CFT at site 5A where a respondent implied that in recent years the efficiencies in services they had achieved had not resulted in benefits to CHs,

"So the evidence for going forward is if we continue here [within the PCT] the more surpluses and efficiencies we make, the more money the PCT will have. There's no guarantee for us that it comes back into community services and I feel that is becoming one of the stronger drivers here."

Not surprisingly the decision to apply to become a CFT was complicated and a range of factors influenced the final decision. Whilst all CFT pilot respondents welcomed the independence CFT

status would bring, they acknowledged that the decision to pursue CFT status allowed the new organisations to remain within the NHS.

While many of the sites reported that their organization had considered the different organizational forms suggested in the government guidance, few reported having seriously considered becoming an independent social enterprise. This finding supports Miller and Millar's (2011) view that, on the whole, NHS staff did not support the setting up of social enterprise and that commissioners' support was also lacking.

Remaining in the NHS provided a sense of security because the NHS 'brand' was understood and valued by the public at large. Equally important however was the sense of security to employees from remaining within the NHS. As a representative at site 3A said, staying within the NHS meant

"... everyone understands the terms and conditions stay the same, and it's not an issue, so the staff and the unions were pretty up for it really."

Additionally, remaining within the NHS, albeit as a more autonomous organisation, provided a measure of security against the risks inherent in changing organisational form. For example managers at site 3A had considered pursuing other organisational forms, including becoming a social enterprise, but had rejected this option because as one participant commented, it

"... just felt a little bit too risky in terms of maybe moving just a little too far away from the standard NHS style models that were available."

After consideration of the different models at site 3B there was still interest in pursuing the CFT model as the '*preferred option for provider services*' despite not being in the pilot CFT programme. The reasons for this included that

“Staff told us that they wanted to be part of the NHS, they valued the NHS, it wasn’t just about pensions actually it was about the whole ethos that being in the NHS was.”

Respondents across sites did not view the option of becoming a social enterprise with great enthusiasm. Much of these concerns related to uncertainty about future viability (Miller et al 2012). For example a representative from site 3B reported that there was considerable reluctance to consider becoming a social enterprise because staff perceived it was *“...a really untested model around large businesses.”* While at site 5B we were told that there was ‘no appetite’ for becoming anything other than “a directly [NHS] provided organisation”.

Site 4A had evaluated all of the different options and had come to the conclusion that CFT status was the best match for their strategic aims. One representative described they were able to identify distinct benefits which were

“ around the freedoms inherent in that separation with regards to being able to invest our savings back into the community to enhance various different services.”

The representative at site 1A reported similar reasons for wanting to become a CFT, but also identified the governance arrangements of the CFTs as *‘the real attraction’* which would *‘allow both the local population and our staff to hold the board to account.’* Additionally, a respondent noted that CFT status allowed the organisation to stay within the NHS brand *‘which is very important to the staff.’*

Participants from comparator sites (who were never part of the CFT pilot programme) painted a mixed picture about their future organisational plans. Representatives at site 1B described how the CHS provider arm of the PCT had considered all organisational models and had initially begun putting together a case to become a CFT. However it became apparent that the

organisation was too small and *“it wouldn’t have been cost effective for us to become a CFT on our own.”*

Respondents also suggested that, as a small CHS provider, they might be vulnerable to a take-over from a larger provider outside of the local area who might *“feel that if we were merged into one organisation, they’d be able to make efficiencies better.”* Participants at this site thought the likeliest scenario would be that the CHS would be dispersed to a range of agencies including: social care, an out-of-hours service, as well as the acute trust. Contrasting views were apparent within site 2B. Representatives reported that commissioners wanted to pursue further vertical integration with acute trusts, whilst the CHS provider arm was keen to pursue horizontal integration with the local council based on their existing experience of integrating professional teams, potentially becoming a care trust. Importantly, commissioning representatives at this site perceived benefits from both models and noted that the integration of CHS and social care services had already *“delivered real benefit; we’ve got demonstrated benefits now around reductions in health inequalities.”*

Ironically, the one social enterprise in our study became a social enterprise because it was too small for Monitor, the FT regulator, to agree that it would be viable as a CFT. Representatives at this site argued that the decision allowed them to *“take forward some of the elements of mutual co-operatives because it’s about what the ethos of the NHS is about, and that’s what the Unions could understand.”* However, they went on to say that in light of their plans to ‘grow’ the organisation they would constantly review *“the structure, the governance and the financial status of the organisation and if we compare social enterprise versus Community Foundation Trust and if it proves that by switching to Community Foundation Trust– is better than what we were doing, then we will reconsider – reassess and reconsider the position, yes”*. In that sense they did not view being a social enterprise as necessarily their final organisational destination.

2. Uses of autonomy

One of the original questions for the study was whether becoming a CFT improved the management of CHS. As none of the pilots had actually become CFTs during the study (or to date), we investigated the interviewees' views of how moving towards CFT pilot status affected the way they ran their organisations, and compared these to what the comparator CHS reported on similar internal management issues. We found that all the sites had the same aims and methods in respect of improving the management of services, and that the decision to become a CFT (or a social enterprise) simply intensified effort. The main aspect reported by respondents was how they were becoming more business-like. Four key areas relating to being more 'business-like' emerged, these were: staffing; service re-design, estate and resource management and future business opportunities. Importantly the data suggested that comparator sites were also engaged in similar initiatives to become more 'business-like'. However, they did not report being engaged to the same level of intensity as the CFT pilot sites, perhaps because they were not subject to such stringent external monitoring as those organisations who had been designated as CFT pilots.

a. Staffing

Respondents from all CFT pilots reported that they were reviewing their main expense, which was staffing costs. This included reviewing not just the productivity of staff but also considering the skill mix within services, as well as looking at issues related to staff contracts. At sites 5A and 2A managers were considering how they could improve the productivity of community nurses. Attention at both sites had focused on increasing the amount of time district nurses spent with patients. At site 5A a respondent said

“We now know for example that our district nurses only spend 50% of their time in face to face contact with patients, so there’s got to be some productivity improvement there.”

Initiatives to develop a more flexible workforce were being discussed at two of the sites. At site 5A they were specifically interested in reviewing the role of unqualified staff and developing a broad competency framework which would allow these staff to complete a range of different tasks as a means to better support qualified staff. Through the introduction of care pathways they also saw the opportunity to challenge whether *‘somebody who’s a qualified nurse needs to be doing that activity.’* Having reviewed the productivity of nursing staff at site 3B, a comparator site, managers were keen to introduce a generalist role arguing,

“It’s not about ‘I need a nurse’, ‘I need a physio’, it’s actually I need skills around empowerment or I need skills in enablement, who might happen to come from a nursing background or a therapy background.”

Managers at site 2A were also looking at staffing ratios as a means to improve flexibility and reported that over the next five years they would like to move from a 78:22 to a 50:50 ratio of qualified to unqualified clinical staff. They envisaged this could be achieved *‘through likely retirees, turnover rates.’*

The impact of the current NHS grading and pay system for NHS nursing staff, ‘Agenda for Change’, on the cost and efficiency of services was frequently discussed. For example a manager at site 2B reported how the introduction of Agenda for Change had led to a perceived inflation in staff grades, particularly within the allied health staff group, which needed to be addressed, they explained how

“So we’ve got too many specialists and whatever, and I think that’s a... a big issue, and that skill mix change has got to be, obviously, addressed.”

Although participants acknowledged that they could do little to change the pay and grading structure of staff until they achieved full CFT status they implied that they would review these structures in the future. Making wholesale changes to the grading scale was not a process to be entered into lightly. At site 2A a participant reflected that *“We understand it’s difficult and relatively few people have done it so far, but it’s certainly not off the table.”*

At site 3A one participant commented

“... there is only one FT in the country that has abandoned the Agenda for Change process and gone for local terms and conditions. So we need to actually look at that and see what is happening nationally in terms of negotiations, because about 80 to 85% of our cost base is staff salary (...) therefore we just need to think about what any nationally negotiated settlements mean, and whether that is affordable.”

Additionally at site 5A senior managers were considering ways in which they could change the nature of the employment contract so that more staff were available at times of peak workload. For example the community nursing service came under considerable pressure during the winter months:

“... so in the summer we don’t have the same pressures that we do in the winter so why don’t we start talking to staff around annualised contracts where they do more work in the winter than they do in the summer.”

Managers were also considering different ways in which staff could be made to work more efficiently. Most sites discussed the use of IT. For example introducing wireless networking so that community nurses could complete case notes away from the office. Managers at site 2A were also contemplating the introduction of mobile working technology as a means to increase productivity.

It was not only clinical staff who were the focus of these changes. Having reviewed their cost structures at site 3A the decision had been made to refine their organisational structure, including taking out a whole tier of management. Representatives at comparator site 2B also reported having to reduce management costs as a means to cut expenditure. At site 2A the board were reviewing back office costs as a means to reduce expenditure. This not only included potentially losing some administrative posts but also initiatives to tighten up on procurement and stock control.

b. Service redesign

All of the sites were considering ways in which they could redesign services in order to make them more efficient. Representatives from comparator site 5B told us this work had been under way for some time

“We’ve got a structure, a service improvement team within the organisation, so the incremental service improvement work and that sort of productive community services, we’ve been doing for a while, really, without internal resources.”

At site 2A they were already seeing improvements in efficiency as a direct result of such initiatives, but they recognised that these developments had to *‘resonate with the PCT’s commissioning strategy.’* For example, a participant described how the PCT had invested substantial sums in the development of a hospital at home scheme which built on the local intermediate care and rapid response service. As a result of that investment they had in the first year saved £2 million worth of bed days in the hospital.

Similar initiatives were being considered at site 3A where they were exploring ways in which to collaborate with partners in the Mental Health Trust to develop clinical pathways that would “...

actually start shifting some of the activity and therefore the tariff work out of the expensive acute care.” While most participants described the impact of these developments in terms of financial savings, at site 5A efforts to redesign clinical pathways were seen as an important part of improving patient care, while at the same time emphasising the contribution of community services, a participant described how

“The role of community services becomes much clearer when you start to look at these pathways because our staff have long-term relationships with patients and they tailor the care and the treatment to that individual and the family.”

c. Estate and resource management

Two of the CFT pilots were considering how to make better use of their estate. They were looking to rationalise their ‘footprint’ and make sure they were using all of their buildings efficiently. At site 3A for example, participants reported that they were exploring how they managed their estate and utilised the space as a means to cut overheads. In particular they reported how they were

“... challenging the assumptions of how much floor space we need for staff that are essentially out and about, or in clinics, or visiting people in homes.”

As previously stated respondents reported that they would be rationalising what they called ‘back office’ services. These initiatives included reviewing administrative services as well as making better use of IT. Moreover, at site 2A a respondent said that the decision had been made by the executive team to cut back on non essential items such as catering for board meetings and first class travel. Whilst it was recognised that these represented comparatively

small savings, the idea was to set an example to the rest of the organisation. Once again similar initiatives were also evident at comparator sites: for example, at site 2B representatives reported reducing management costs as well as reviewing the home visiting process to improve its efficiency.

Importantly, at comparator site 1B a representative argued that moving to a more autonomous status in whatever organisational form was not undertaken purely to achieve cost savings but was about wider ambitions to improve service delivery, a view that was not advanced at other sites. This respondent went on to argue how

“you can get really lost in this, it’s all about cost savings and slashing and that can be very short sighted because you can slash and burn and do cost savings year one and then you really struggle for year two.”

d. Business opportunities

Although the pilots had yet to secure full independence from their PCT they had begun to consider future opportunities within the local healthcare market.

At site 5A the new levels of autonomy that increasing independence had already brought were an opportunity to develop business independently of the PCT. As a result a participant described how they had

“.... started looking at the threats and opportunities for our market, with the aim of becoming the provider of choice rather than the provider of last resort.”

This provider took the view that it should develop only those services that were core to their business plan:

“... where we feel our weaknesses are in service delivery, we would want to talk to commissioners about whether we continue to provide certain services.”

At site 3A respondents were considering ways in which they could develop their business to move clinical activity out of the acute setting and into the community, as one participant described

“We are really well positioned in a number of areas which is about shifting activity out of acute centres into community settings or closer to home. Now clearly the district nurse and integrated care speak to that agenda, but on top of that we’ve got very strong services in muscular-skeletal, in sexual health, in podiatry and in dentistry, and those are all areas where we’d be looking to try and expand what we do.”

They were also actively bidding for services outside of their geographic area although this work was in its infancy.

Despite this enthusiasm, delays in the process of becoming a CFT meant that pilots were not yet able to pursue these opportunities as vigorously as they might wish. At site 3A they recognised that once they had been granted CFT status they would be able to *“go into some quite interesting risk sharing and dynamic relationships with other providers.”*

Comparator sites were also looking at ways in which they could develop their core business. At site 1B we were told that *“.. we’re always looking for opportunities at the moment, to raise additional income and things.”* This site had recently tendered, as the lead provider, for a mental health contract in partnership with the local NHS mental health trust and GP practice. New business opportunities such as these are lucrative particularly at a time of financial restraint: for example, this new contract was reported to be worth over a million pounds.

All the sites in the study reported becoming more business-like, irrespective of whether or not they wanted to become a CFT. The process of separating from the PCT itself and becoming more autonomous in this way appeared to be driving the same kind of behaviour across all of the sites. In other words the impetus to become a CFT was not the sole driving force, all sites wanted more autonomy to run their own affairs.

Discussion and conclusion

Our study has limitations because the proposed changes to allow the formation of CFTs did not go ahead, so it is not possible to find out what the effect of such changes were, including both whether increased organisational autonomy led to better performance or whether accountability to local people was improved. Nevertheless, we were able to investigate the attitudes of all the providers of CHS to the plans to increase their managerial autonomy, whether simply by separating from PCTs (which were becoming mainly commissioning organisations) or by becoming CFTs (NHS organisations with greater formal autonomy from central control). Thus we were able to investigate the importance of autonomy to NHS managers. As no CFTs have yet been formed, this study provides the only evidence about increasing autonomy for CHS in England.

The government's intention to transform the way in which CHS services are organised was in large part met with enthusiasm by the participants in the study, all of whom welcomed the opportunity to run their services with less interference from higher echelons of the NHS hierarchy. Participants from CFT pilots were enthusiastic about their new organization being granted more autonomy and were keen to use the new opportunities afforded to them to improve services. Equally, participants from comparator sites were also clear that the greater

autonomy offered by a split from PCTs (without becoming CFTs) would still provide opportunities to develop services and improve organisational performance in a more autonomous manner than was previously possible.

However while all participants thought that greater autonomy might bring benefits to their services, they also recognized that such changes would bring some risk. After all, being more autonomous implied taking greater responsibility. This led to most articulating a desire for greater autonomy within the NHS rather than independence from the NHS. The opportunity to establish an organization outside of the NHS, by becoming a social enterprise, was not greeted with eagerness, by most sites, in fact quite the opposite. Participants from across most sites suggested that leaving the NHS presented a range of threats. These included risks to staff: for example, concerns about the loss of NHS terms and conditions of employment. More significantly there were concerns about the survival of small scale organisations in what was seen to be an increasingly uncertain market. This uncertainty related both to the broader financial context of public services and also to the increasingly diverse nature of providers of health services to NHS patients. Such concern confirms Checkland et al's (2012) view of the existence of shared formative values related to NHS 'family' as well as the acknowledgement of an NHS brand. There was however a small number of participants, mostly, but not exclusively, from CFT pilot sites, who reported that one of the strategies they were considering as a means to make their organisations more efficient was to challenge the pay levels ascribed by the national pay scales in the NHS, Agenda for Change. In other words, while these managers wanted to minimise the risks associated with moving outside of the NHS family at the same time they wanted to abolish one of the corner stones of employment within the NHS.

As part of the general transformation of CHS organisations, whether it be to CFT status or to integrate with mental health services or acute health care providers, representatives from across all sites discussed a similar set of initiatives they had either begun, or were currently

considering, in an effort to make their business more productive and to deliver better services to patients. Irrespective of organisational destination all of the CHS organizations in the study appeared to be clear that increased autonomy would be beneficial.

This finding has particular resonance for debates about hybrid organisational forms and organisational isomorphism taking place in the field of public management (Ashworth et al 2009). We found that the institutional environment in which all CHS operated was that of a quasi-market, and this had the effect of leading to isomorphism in relation to the main goals of the CHS irrespective of the actual organisational forms in which they found themselves. Increasing organisational autonomy in order to improve efficiency and service quality were the key drivers for all the CHS in the study. The directive to change the way in which CHS were delivered outlined in the 'Transforming Community Services' programme (2009) suggests a politically influenced coercive requirement, one which publically funded health organizations could not refuse (Millar 2012). However, being directed towards different organisational forms did not demonstrably alter the way in which these organisations behaved as the evidence presented in this paper demonstrates.

The experience of evaluating the CFT pilot programme, particularly during a period of financial retrenchment, appears to support the view that the development of managed markets, like the English NHS, may not always develop in the way policy sets out, which may sometimes result in policy makers being forced to make further structural changes (Hughes et al 2011). Most participants were wary of organisational reforms at a time of restricted public spending, and consequently few viewed the prospect of moving outside the NHS with any enthusiasm. This wariness supports Anheier's (2011) view that sectors characterized by a high degree of complexity and uncertainty, such as the NHS, are often difficult for governments to steer and control.

Efforts to reorganise the public sector along NPM lines in England are long standing. Successive governments have attempted to change organisational structures in the belief that different types of organisations will be more productive, particularly if they are granted more autonomy. This paper demonstrates that it is not the precise organisational form which is important to public sector organisations, but that increasing autonomy is valued by those managing services. However in respect of health services in England, there is no evidence that such autonomy actually improves performance.

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